DOCUMENT RESUME

ED 189 755 EC 124 295

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TITLE New Tentative Experimental Treatment Approaches to Autism (Breaking Through the Impenetrable Block of Autism).
PUB DATE [78]
NOTE 24p.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Autism: Behavior Modification: Children: Exceptional Child Research: Literature Reviews: *Program Effectiveness: Psychotherapy: *Teaching Methods: *Therapy

ABSTRACT

Literature on treatment approaches used with autistic children was reviewed and the effects of two treatment approaches, psychotherapy and behavior therapy, on three autistic children (10 to 15 years old) were investigated. Data from the literature was considered in light of the following questions: What are the aims or goals in treating autistic children, as practiced in the Lowenstein Therapeutic Community? How much is the condition of autism under voluntary control of the autistic child? Is the condition of autism sometimes relatively or totally impervious to normal human and humane efforts to make contact, and hence communicate with the individual? How are we justified in using desperate means in order to possibly achieve uncertain ends? Ss were submitted to four learning and performance tasks under the conditions of normal instruction, firm or intense instruction, harsh guidance, mild guidance, and firm instructions and harsh versus mild guidance. Among conclusions were that firm or intense instructions are more effective than mild or normal instructions with all types of performance tasks used and with all types of autistic children investigated, that harsh guidance is more effective than mild guidance in speed of performance of simple and more complex tasks with all kinds of autistic children studied, and with more gross manifestations of autism, firm insturctions and harsh methods appear to be especially effective. (SBH)

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NEW TENTATIVE EXPERIMENTAL TREATMENT APPROACHES TO AUTISM

(Breaking through the impenetrable block of Autism)

-by-

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NEW TENTATIVE EXPERIMENTAL TREATMENT APPROACHES TO AUTISM

(Breaking through the impenetrable block of Autism)

1. Introduction.

A. Treating the apparently untreatable.

Anyone who has ever taught or treated severely autistic children must have noted the great difficulty involved in helping them. It is as if one is up against an impenetrable wall, which neither gives in nor provides any opportunity for communication. There are exceptions to this, but even here, success is limited and often only temporary, and extremely difficult to achieve when it is achieved.

The autistic child is much like some shape that rarely accepts contact, and almost natually returns to its own personal condition once the intrusion into its life space has gone away or given up its effort. The autistic child returns to its former self contained, torpid or ritualistic orientated state with an apparent relief that the intrusion has passed and he can be as he thinks he is meant to be. Such a tought process may not be going on at all, and is merely an assumption by an outsider who seeks to understand the world of autism.

The basis for partially adopting this volitional view of the autistic child demands a sequence of approaches to the problems of autistic children. It is difficult to prove, but everyone who has ever worked with autistic children must have, from time to time, considered that were one dealing with a normal child manifesting the same or similar types of behaviour shown by the autistic even in the minor form, the interpretation of what is taking place could well have been seen as a "battle of wills". According to this, the autistic child is possibly a combination of being negative, or wilful, or unable to behave as others do. By this I mean that they are individuals who do not want to or can not communicate and inter-act with others, and who respond with some lack of pre-

dictability to their enviroment.

B. Battle of Wills or Pressure Against Predestined Inscrutability.

This leaves us with some uncertainty, and hence questions. These include: -

1. What are the aims or goals in sequential form in treating autistic children, as practised in the Lowenstein Therapeutic Community?
2. How much is the condition of autism under the voluntary control of the autistic child?
3. Is the condition of autism relatively or totally impervious to normal human and humane efforts to make contact and hence communicate with the individual in question?
4. How far are we justified in using desperate means in order to possibly achieve uncertain ends with very profoundly autistic individuals?

It will be the objective to seek answers to these questions as well as to present some tenative conclusions based on, as yet, limited data, from research into some of the treatment approaches practised in the Lowenstein Therapeutic Community.

1. What are the aims or goals in treating autistic children, as practised in the Lowenstein Therapeutic Community?

The objectives or aims of treatment provided in the Lowenstein Therapeutic Community include among others:

(a) To open up the child, to communicate with the outside world.

(b) To motivate the child to co-operate with adults and other children.

(c) To eliminate bizarre, negative or maladaptive behaviour.

(d) To educate the child to his potential in the basic subjects and in areas of personal interest.

The Lowenstein Therapeutic Community consists of a small number of children who are boarding and living in two houses. They have a great variety of different problems. Only a very small number of autistic. The rest consist of children of both sexes and all ages (9-16) who have learning problems, are underachievers, are emotionally disturbed children who are either acting out or are withdrawn and who vary in I.Q. from 75 - 135. Since all children are taught totally as individuals, there is no competition for academic standing between the children.

The children mix freely and are encouraged to live with one another in harmony. This can only be achieved by setting high standards of personal conduct, showing concern for one another, and receiving leadership by staff whose own behaviour reflects high standards. The regime is structured and organised with a great emphasis on total care or love, psychological treatment, and, of course, indivualised education.

The children have varied needs and hence remain for indefinite periods. The advantages of having children, most of whom are not autistic, means that the autistic children are surrounded predominantly by models at variance with themselves. This makes it possible for autistic children to imitate different behaviour to their own, hopefully to identify with more adjusted demeanour and eventually to have a more acceptable identity.

2. <u>How much is the condition of autism under voluntary control of the autistic child?</u>

Suffice to say that whether autism is under voluntary or involuntary control, it is at least partly immaterial. This is with the exception of those whose autism is under greater personal control and who may be reached by relatively more rational therapeutic approaches than those whose autism is mostly beyond conciousness and is not governed by personal will to any degree.

Let us compare the treatment approaches that might be adopted under any of the three possible conditions:

(a) Autism under the conscious and hence voluntary control.

(b) Autism under the non-conscious and hence involuntary control.

(c) Autism being under varying degrees of conscious and non-conscious control.

These are alternatives which may occur among different autistic children. The treatment approaches adopted should therefore cover any of these possibilities to be effective, especially as it is by no means certain which form predominates in any particular child. If some drug or other method existed which might make it possible for an autistic child to have a short, but lucid moment in order to reveal to us his state of mind when it is not so lucid, we might learn something truly vital about the inner scene to autism, but we are, as yet, a long way from this. Much could perhaps be learned from autistic children who have been helped or even cured. Here we might learn what is truly happening in their inner world, which is so successful in shutting us out. The problem here undoubtedly is that such retrospective analysis of former conditions may be impossible, because total cures are rare in the case of the profoundly autistic, this being the very condition that needs to have the greatest help. This objective assessment by former mental patients is in itself suspect, since the very disturbance at the time of the illness is likely to cause a distortion during coeval revelation.

We are, therefore, left with a considerable amount of uncertainty as to the state of mind and therefore the capacity to benefit from particular therapeutic approaches, except in as far as how subsequent behaviour is affected.

Therefore, when a method is used, which decreases the autism, we as therapists are reinforced, and hence encouraged to continue along the same line of approach.

The very approach one selects may also be based on a personal predilection as well as having its basis in ones own personal experience and training.

In a sense the question of whether the condition of autism is voluntary or not, becomes irrelevant when we are faced with the actual child with whom we can have no rational therapeutic dialogue. Our objective must be "to break through the impenetrable block of autism" or help the child to break out of his own limited and obviously satisfying inner world and enter our own. To do this, however, requires a thorough understanding of the child in as far as this is possible, and all the energy and imagination as well as inventiveness, dedication and perseverance are required in order to continue helping such a child. This takes us to our third question.

3. Is the condition of autism sometimes relatively or totally impervious to normal human and humane efforts to make contact, and hence communicate with the individual ?

Despite the lack of objective evidence, I have now decided the following:

1. There is some area of will or willfulness acting in the autistic individual.
2. That there is no need to distinguish between the voluntary and the involuntary aspects of the condition, when using therapeutic approaches, because whatever the associated features, the end product must be the same, i.e. the child must become less autistic and more normal in his behaviour.

In order to make the child less autistic, two basic attitudes prevail as to how these ends can be achieved:

1. To coax or seduce the child outside the boundaries of its own autism.
2. To force the child outside the boundaries of its own autism.

Usually the first of these alternatives is practised initially, and, if failing, some therapists use the second alternative. Other therapists consider the second alternative unethical or otherwise undesirable, hence they eschew it. They prefer either to leave the child as he is, or persist with the same positive methods that have borne little fruit.

Those who persist with methods which may appear to be less humane, are considered by their extreme critics as dangerous or even sadistic in their practise. It is vital that when aversive techniques are used, there should be consultation with staff as to the extent and to the duration of the practise of aversive methods. Limitations must be placed on what is being done and the duration of the practise. Periodic objective assessments and reassessments of progress should be carried out to ascertain whether there is any justification for continuing to use the method.

Therefore, despite the fact that the condition of autism is sometimes impervious to more "humane" procedures, more drastic procedures, must be applied with care and for a set period only. This should be followed by a careful and objective appraisal of the situation. Should there be no improvement, other methods should be attempted, rather than continuing with procedures that have shown themselves to be ineffective and hence abortive.

4. <u>How far are we justified in using desperate means in order to possibly achieve uncertain ends?</u>

Having decided that more intense or exaggerated approaches are demanded with some autistic children, we must now decide the quality and degree of when to persist with it, and when to cease such approaches. When, for instance, are aversive techniques justified and unjustified? I will try to answer that question in a moment. Firstly, however, let me reply to the earlier point, when to persist and when to desist with the practice,

be it positive or negative.

Firstly, the procedures used must be clearly delineated. Secondly, the results of the treatment should be objectively measured. Finally, it is vital to observe the child overall in order to ascertain whether there are any side effects (positive or negative) associated with the treatment process.

Let us illustrate the point by an actual member of haphazard treatment sessions which are carried out by an unsystematic therapist on an autistic subject. The result of the treatment may not have been measured objectively and, in fact, could not be measured objectively because of the great number of variables acting on the child. One is therefore uncertain what is actually achieved. Furthermore, the child begins to regress. This is undoubtedly in response to the insecurity experienced in the handling the child has received. The form of regression is urination and defacation every night.

It becomes clear from this that something is wrong with the way the child is being handled and the only variable that has changed is that of the therapist and his unsystematic approach. The truth of this is verified when the enuresis and encopresis ceased almost immediately when the therapist ceases his activities. At that point, new methods of treatment are instituted.

Let us return now to our second point: "When are aversive techniques justified and when are they not justified?"

There are those who are toally opposed to aversive methods for gaining attention, training, educating and most especially fostering communication between the autistic child and other individuals. There are still others who are prematurely eager to use aversive methods, when more positive approaches could lead to similar or even better results.

The side effects of aversive techniques are well known, and this is, perhaps, the major reason for avoiding them if it is at all possible. My position is that positive methods, rather than negative ones, should always be used in preference. Should positive methods fail, the mild aversive techniques might be employed. The severity of the aversive methods should be increased with the utmost caution, since if they are excessive, they are likely to produce severe regression in the child. This includes the child resuming enuresis and encopresis, total withdrawal of even catatonic type behaviour.

II Experimental Research.

A. Introduction to methods used.

The experimental research in the Lowenstein Therapeutic Community hopes to test a variety of treatment approaches by carefully measuring specific techniques applied to three autistic children. It is hoped to established in this way, which procedure or procedures are most effective, or not ineffective in producing changes. It is hoped that none of the methods used would have long term negative repercussions. Children are therefore observed for a period of time. This is followed by the experimental procedures to be described; then a follow-up is of interest to see that there is no long term negative effects and that there is a predominant degree of positive repercussions to the treatments used.

B. The Subjects.

1. General Information.

The experimental group consists of three subjects who suffer from a variety of autistic symptoms. They were aged 10 - 15 and have been a problem to their parents and to their school for years. They could not eventually be assimilated into the normal classroom.

All the children studied, with the exception of one, have been diagnosed by a specialist as being autistic. They suffer from a number of specific symptoms, associated with or part of the autistic syndrome. These include:

(a) The inability to communicate normally, i.e.

(i) No speech, or limited speech.

(ii) Lack of non-verbal communication.

(b) The inability to relate normally, i.e.

(i) Lack of any way to maintaining contact.

(ii) Lack of attention to others.

(iii) Lack of desire or ability to seek and interact with other people.

(c) Limited hand - eye co-ordination.

(d) Odd postures and behaviour.

(i) Head holding.

(ii) Hand holding.

(iii) Animal sounds.

2. Specific Information.

The subjects studied varied in their capacity to communicate and be capable of diagnosis. They also varied in their active contact with the enviroment.

The table which follows summarises the diagnosis of the three children on the Wechsler Intelligence Test for Children, where available, and their achievement in the basic subjects.

	(a) (Male)	(b)(Female)	(c) (Female)
Age	14.05	11.09	10.00
I.Q. - Verbal	59	-50	Nil
Non-verbal	82	105	Nil
Full scale	71	-	Nil
Reading Age	11.1	5.05	Nil
Spelling Age	10.02	nil	Nil
Arithmetic Age	7.09	4.09	Nil
Speech	Yes	Yes	No

Subject (a), the oldest, was male and had most contact with his enviroment. Subject (c), a girl aged ten, had the least contact and had virtually completely withdrawn. Subject (b), aged 11.09, was in between the two extremes.

The subjects may be taken as occupying not merely three age groups but three positions, from the very autistic, to the moderately autistic continuum.

Subject (a) is a relatively effectively communicating autistic boy aged 14. He is blond and is almost six feet tall. He is attractive and has blue eyes and speaks with an automaton type of voice. He frequently giggles and holds his arms in a peculiar position, bent at the elbows with upward turned shoulders and the back of the hand held outwards, fingers pointing downwards. At odd times he will shout for no apparent reason.

Otherwise, his verbal I.Q. is 59, and yet his reading age is 11.01, which is quite adequate for normal reading. His spelling age is 10.02, and his mathematics age 7.09. He has good speech, but most of his communication is ego centred. His non-verbal I.Q. is 82.

Other peculiarities are that he walks, moving his head like a duck, up and down.

He eschews physcial contact with others, but is aware of his own personal needs and preferences.

Subject (b) is a child of 11.09 at the time of the experimentation. She has been diagnosed autistic, and yet is capable of some communication after six months treatment in the Lowenstein Therapeutic Community. Initially, when she arrived, subject (b) wet herself, undressed in public, scratched herself viciously until she bled, specially when required to do anything she disliked or whenever reprimaned. She also has the habit of going into other children's beds, tearing her own and other children's clothes, and using such expressions as her own name coupled with whatever she wanted, i.e. "F- do it," "F's clothes", etc.

This type of behaviour, with the exception of lack of use of pronouns such as "I" or "you" has now been severely reduced. (b) only in times of extreme stress will return to self destructive or destructive behaviour. When she returns after a period at home, following holidays, there is some difficulty and there is a period of regression, but this is gradually overcome.

On the Wechsler Intelligence Test for Children, her verbal I.Q. is below 50, while on the performance scale she scores at 105. She is just beginning to read and has now reached a modest standard of 5.05 in this basic subject. She cannot as yet spell and her mathematics ability level is at 4.09.

Subject (c) is the youngest of the autistic children. She rarely uses language of any kind and then it is not used appropriately. She is an attractive girl from the Sudan, aged ten. Attempts to diagnose her condition in the Sudan and Egypt had failed. She cannot maintain a long period of eye contact as yet, and has failed to respond measurably, except through very firm direction.

On arrival she was doubly incontinent, both at night and during the daytime. Initially she refused to feed herself and spat out the food she was fed. Within a month at the Lowenstein Therapeutic Community her behaviour in this respect had ceased. Where she failed to respond to her name being called, she now responds. She now feeds herself, but still has to be taken to the toilet, washed and helped with her dressing. She has begun to perform simple tasks, albeit with some inconsistency. These included the clearning and washing of tables, and the performance of such non-verbal tasks as form boards and jigsaw puzzles as used in the research.

C. Experimental Procedures.

1. General Techniques for Fostering Attention, Imitation, Identification and Identity in Autistic Children.

(a) Using affection and warmth while touching the child's hand and moving them rhythmically up and down. This engenders, in due course, the desire of the child to imitate this movement, which should increase in duration and complexity of the movement and the rhythm.

(b) Using music and rhythm of music in conjunction with the limitation of movement.

(c) Using primitive attention getting devices such as touching the hands, the face and, in so doing, using such contact to foster eye to eye communication. The child will often look at the eyes of the psychologist by using his two hands to link head and eyes.

(d) Encouraging sound production and sound imitation.

(e) Shaping more complex sounds by imitation.

(f) Developing "linkage" to other persons. This is done initially using a rope or

string, whereby the child is connected to an adult or another child and is led from place to place accompanying the person.

(g) Getting the child to express positive and negative emotions:

(i) Aggression, i.e. training the child to hit the therapist with hands.

(ii) Fear, i.e. making frightening faces at the child or taking them to the brink of a dangerous situation.

(iii) Affection, i.e. by training the child to imitate signs and sounds of warmth and affection as demonstrated by the psychologist.

(iv) Pain, i.e. producing feelings of pain through a variety of techniques.

(v) Pleasure, i.e. producing signs of pleasure by a variety of techniques.

(h) Developing a total self-awareness through such techniques as "mirror training", i.e. getting the child to see itself in a mirror combined with one, two, three, four, five and six.

2. Specific Experimental Procedures Tested.

(a) Learning and responding based on intensive stimulation, i.e. love versus normal commands and instructions.

(b) Learning and responses based on harsh (extremely firm) versus mild or normal therapeutic handling.

(c) The combination of mild versus severe therapeutic handling by the same therapist.

(d) A combination of mild versus severe measures by therapists reversing roles.

3. Response Tasks to be Learned.

(a) A simple peg borad hand and eye co-ordination task requiring distinguishing

between round and square pegs by placing them in the appropriate aperture of two form boards.

(b) A more complex task involving a small jigsaw puzzle.

(c) Removing dishes from a table by piling them in an orderly fashion.

(d) The setting of table, consisting of a plate, a knife, a fork, a spoon and a cup.

4. Criteria of Objective Assessment.

All learning performance tasks were timed with a stopwatch. In the case of the autistic child refusing or "freezing" the performance of the tasks, the child received firm guidance to complete the task.

D. Results.

Speed of learning in seconds with three autistic children and three repetitions of four kinds of learnings are summarised. Tasks (1), (2), (3) and (4) under conditions of learning:

(A) Normal instruction,

(B) Firm of intense instruction,

(C) Harsh Guidance,

(D) Mild guidance,

are measured for child (a), (b) and (c).

The three autistic children (a), (b) and (c) were submitted to four learning and performance tasks.

With (a), (b), (c) and (d) one therapist was involved only.

(E) Firm instructions and harsh versus mild guidance, using two therapists reversing roles on the four tasks.

Table 1 indicates the speed of learning of four tasks, using intense versus normal instruction.

TABLE 1. Normal Instruction Versus Mild Instruction on Four Performance Tasks (1, 2, 3 and 4).

		Child (a)	Child (b)	Child (c)
TASK 1 - A simple form board requiring round and square pegs (mean times taken on three trials).				
A.	Normal instruction	63	161	185.3
B	Firm or intensive instruction	24	42.6	57.6
TASK 2 - A more complex jigsaw puzzle requiring differentation between four shapes (mean times taken on three trials).				
A	Normal instruction	71.3	173.6	214
B	Firm or intensive instruction	32.0	50.0	92.3
TASK 3 - Removing dishes and cutlery from table and piling them neatly (mean times taken on three trials).				
A	Normal instruction	85	97.6	112.3
B	Firm or intensive instruction	51.6	56.3	66
TASK 4 - Setting table (plate, knife, spoon, cup placed in appropriate positions) (mean times taken on three trials).				
A	Normal instruction	102.3	138.0	252.3
B	Firm or intensive instruction	59.0	127.3	160.0

TABLE 2. Firm Instruction plus harsh guidance versus normal instruction and mild guidance towards performing tasks.

		Child (a)	Child (b)	Child (c)
TASK 1 - A simple form board requiring differentiation between round and square pegs (Mean times taken on three trials).				
C	Harsh guidance	37.3	44.6	67.3
D	Mild guidance	67.6	95	145.3
TASK 2 - A more complex jigsaw puzzle requiring differentiation between four shapes (mean times taken on three trials).				
C	Harsh guidance	46.6	57.3	69.6
D	Mild guidance	54.6	60.3	91.0
TASK 3 - Removing dishes and cutlery from table and piling them neatly (mean times taken on three trials).				
C	Harsh guidance	32.6	39.3	80.3
D	Mild guidance	55.6	60.3	102.3
TASK 4 - Setting table (plate, knife, spoon, cup placed in appropriate positions) (mean times taken on three trials).				
C	Harsh guidance	40.3	56.6	81.3
D	Mild guidance	52.6	90.0	152.0

TABLE 3 Firm instruction and harsh versus mild guidance towards performance of tasks 1, 2, 3, 4 with two therapists reversing roles.

		Child (a)	Child (b)	Child (c)
TASK 1 - A simple form board requiring differentiation between round and square pegs (mean times taken on three trials).				
C	Harsh guidance	56.6	53	80
D	Mild guidance	48	75.3	100
TASK 2 - A more complex jigsaw puzzle requiring differentiation between four shapes (mean times taken on three trials).				
C	Harsh guidance	26.6	62.3	85
D	Mild guidance	46.6	72.3	95.3

		Child (a)	Child (b)	Child (c)
TASK 3 - Removing dishes and cutlery from table and piling them neatly (mean times taken on three trials).				
C	Harsh guidance	61.4	134	165.3
D	Mild guidance	82	160.6	195
TASK 4 - Setting table (plate, knife, spoon, cup placed in appropriate positions) (mean times taken on three trials).				
C	Harsh guidance	66.6	83.3	184.6
D	Mild guidance	81.3	114	202.3

TABLE 4. Normal instruction versus mild instruction on four performance tasks (1, 2, 3 and 4).

	Child (a)				Child (b)				Child (c)			
Tasks	1	2	3	4	1	2	3	4	1	2	3	4
A Normal instruction	63.0	71.3	102.3	85.0	161.0	173.6	138.0	97.0	185.3	214.0	112.3	252.3
B Firm instruction	24.0	32.0	59.0	51.6	42.6	50.0	127.3	65.3	57.6	92.3	66.0	160.0

TOTALS	Totals	Mean
Normal Instruction	1655.7	137.975
Firm Instruction	818.7	58.225

TABLE 5. Firm instruction plus harsh training versus normal instruction with mild guidance on four performance tasks (1, 2, 3 and 4.)

	Child (a)				Child (b)				Child (c)			
Tasks	1	2	3	4	1	2	3	4	1	2	3	4
A Firm instruction and harsh guidance	37.3	46.6	32.6	40.3	44.6	57.3	39.3	65.6	67.3	69.6	80.3	81.3
B Mild guidance and normal instruction	67.6	54.6	55.6	52.6	95.0	60.3	60.3	90.0	145.3	91.0	102.3	152.0

TOTALS	Totals	Means
Firm instruction and harsh guidance	662.1	55.175
Mild guidance and normal	1026.4	83.833

TABLE 6. Firm Instruction and Harsh Guidance versus normal instruction and Mild Guidance in Performing Tasks 1, 2, 3 and 4 (Two Therapists revising roles)

	Child (a)				Child (b)				Child (c)			
Tasks	1	2	3	4	1	2	3	4	1	2	3	4
C Firm and harsh	25.6	26.6	61.3	66.6	53.0	62.3	134.0	83.3	80.0	85.0	165.3	184.6
D Normal and mild	48.0	46.6	82.0	81.3	75.3	72.3	160.6	114.0	100.0	95.3	195.0	202.3

TOTALS	Totals	Means
Firm and harsh	1027.6	83.633
Normal and mild	1272.7	106.058

Conclusions:

1. Firm or intense instructions are more effective than mild or normal instructions with all types of performance tasks used and with all types of autistic children investigated in this research.
2. Harsh guidance is more effective than mild guidance in speed of performance of simple and more complex tasks with all kinds of autistic children studied in this investigation.
3. With more gross manifestations of autism firm instructions and harsh methods appear to be especially effective.
4. In reversing roles and using two therapists, there is some deterioration in performance and the deterioration is greater with more grossly disturbed autistic children.

5. As the complexity of the task increases, better performance occurred with more harsh guidance.

6. The complexity of the task was not always an indication of the speed of the performance by the autistic child. More important was the mood and desire to concentrate and co-operate which was a factor in the successful completion of the task in the shortest possible time.

Discussion:

The research, which at present is limited, seeks to establish which experimental procedure is most effective in teaching or training three autistic children, given a variety of tasks varying in complexity. The autistic children also varied in the severity of their disturbance. The method of estimating learning is from timing of the response or timing of the duration of the task being completed.

From the results and conclusions, it is evident that autistic children investigated work best under conditions of a particular therapist working on his own, under pressure rather than under mild conditions, and under firm direction rather than normal direction.

Initially, the subjects were induced to follow the therapist who acted as a model and then they were provided with guidance, including pushing and pulling and manipulating subjects limbs to perform a simple and complex learning tasks.

Later, it become increasingly apparent that the subjects co-operated more and more by doing what they were asked to do with less and less pressure or guidance by the therapist. The process of transition from guided to self initiated responding was a slow one, requiring many repetitions and extreme patience. It also required some very forceful techniques to gain and hold the attention of the autistic child.

A three month follow-up indicates that the efficiency of the performance is maintained. Ideally, a control sample would have provided more irrefutable evidence for using firm instruction and harsh guidance. There are, however, certain problems in here. Firstly, the main obstacle to overcome is to find a match control for particular autistic children. Secondly, a small sample size mitigates against drawing firm conclusions, even had there been well matched control subjects. Had there been such subjects, it might have been anticipated that more convincing conclusions, however, might have been drawn.

The gaining of admission into the world of the autistic child is extremely difficult. The child finds it easy and appears to be determined to shut out the existence of the world outside and those who live in that world. Finding a key whereby access is gained and maintained is extremely difficult. A great deal of searching and researching is still necessary to find more general approaches that are effective with the greatest number of autistic children, although it may be that the most effective procedures are dictated by the individual needs of a particular autistic child.

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